AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 44A114 NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND IDENTIFICATION NUMBER: A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 483.25(d) NO CATHETER, PREVENT UTI (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214 (X5) PREFIX (EACH CORRECTION SHOULD BE COMPLETE DEFICIENCY) F 315 483.25(d) NO CATHETER, PREVENT UTI TAG (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED TO COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED TO COMPLETED TO COMPLETED (X3) DATE SURVEY COMPLETED TO COM	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	4500	12/09/12	OMB NO	4 APPROVI 0. 0938-03
INME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND STREET ADDRESS, CITY, STATE 2IP CODE 3225 FERNBROOK LANE NASHVILLE, TN 37214 FROUGHTS PLAN OF CORRECTION SHOULD BE PREFIXED THAT THAT THAT THAT THAT THAT THAT THA	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE:	SURVEY
LAKESHORE HEARTLAND STREET ADDRESS, CITY, STATE 2IP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214 REQUIATORY OR LSC IDENTIFYING INFORMATION) FREST TAS F 315 A83.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indivelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is inconfinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by. Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff provided proper cleaning to prevent possible urinary tract infections for one resident (#8) of sixteen residents reviewed. The findings included: Resident #8 was admitted to the facility on June 11, 2010, with diagnoses including Athelimer's with behaviors, Depression, Osteoarthritis, and Hypothyroidism. Medical record review of the resident was frequently incontinent of the bladder and was totally dependent for tolieting and personal hygience care. Medical record review of the resident's care plan dated October 17, 2012, revealed "assist with per care after each inconfinent personal hygience care.			44A114	B. WING_		40.	
CACH DERICIENT WITH THE RESULTATION DATE OF THE RESULTATIVES SENDATURE 17AS SUMMARY STATEMENT OF DEFICIENCES PAPELL RESULTATIVES SENDATURE 17AS SUMMARY STATEMENT OF DEFICIENCES PAPELL RESULTATIVES SENDATURE 17AS PROPERTY CACHE PROJECT OF THE APPROPRIATE DEFICIENCY OF THE A				ST	REET ADORESS, CITY, STATE, ZIP CODE		25/2012
SUMMAY STATEMENT OF DEPOCHOLES (ACAPT DEPOCHANCES MASS TATEMENT OF DEPOCHES PORT TAG SOLUTION OR USE DEPOCHE	LAKESH	ORE HEARTLAND		1	3025 FERNBROOK LANE		
PREFIX RESULTIORY OR ISC IDENTIFYING INFORMATION) F 315 SS=D Based on the resident's comprehensive assessment, the facility without an indiveiling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent uninary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff provided proper cleansing to prevent possible uninary tract threatment from trainment and services to prevent uninary tract infections are in 10/30/12. All nursing staff and infection control/standard precautions, was initiated for all nursing staff or 10/30/12. All nursing staff shall receive and review gnaployees shall receive and review and infections for one resident (#8) of sixteen residents reviewed. The findings included: Resident #8 per administrative nursing staff for one week, then one per week for 4 weeks. Additional continue with 4 per week for one week, then one per week for 4 weeks. Additional continue with 4 per week for 6 weeks. The form		SUMMARY STA	TEMENT OF DEFICIENCIES				
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff provided proper cleansing to prevent possible urinary tract infections are in place for any resident. The findings included: Resident #8 was admitted to the facility on June 11, 2010, with diagnoses including Athelmer's with Behaviors, Depression, Osteoarthritis, and Hypothyroidism. Medical record review of the Minimum Data Set dated October 9, 2012, revealed the resident was frequently incontinent of the bladder and was totally dependent for toileting and personal hygiene care. Medical record review of the resident's care plan dated October 17, 2012, revealed "assist with peri care after each incontinent episode" Arrogy pireferons on current treatment for urinary tract or other infection. On 10/30/12, the Resident was placed on alert charting to observe for any signs or symptoms of current treatment for urinary tract or other infection. On 10/30/12, the Resident was placed on alert charting to observe for any signs or symptoms of current treatment for urinary tract or other infection. On 10/30/12, the Resident was placed on alert charting to observe for any signs or symptoms of current treatments for urinary tract infections and infection. On 10/30/12. All numsing staff shall receive packet the function programs infection. On 10/30/12, all runsing staff shall receive and review packet by 11/8/12. All now nursing staff reveals that numsing staff on 10/30/12 and review packet by 11/8/12. All review of the r		CACH DEFICIENCY	MIST RE DOCCEDED BY FILL.	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	KÔULD RE	(X5) COMPLETIO DATE
	SS=D	Based on the reside assessment, the fac resident who enters indwelling catheter is resident's clinical corcatheterization was rewho is incontinent of treatment and service infections and to rest function as possible. This REQUIREMENT by: Based on medical refacility policy review, and to ensure staff prevent possible urinatesident (#8) of sixtee the findings included. Resident #8 was adm 1, 2010, with diagnosith Behaviors, Depresident and October 9, 2012 equently incontinent to trailly dependent for to regione care.	ent's comprehensive sility must ensure that a the facility without an so not catheterized unless the indition demonstrates that necessary; and a resident bladder receives appropriate es to prevent urinary tract tore as much normal bladder. If is not met as evidenced excord review, observation, and interview, the facility provided proper cleansing to any tract infections for one en residents reviewed. In the facility on June es including Alzheimer's ession, Osteoarthritis, and excord the Minimum Data Set 2, revealed the resident was of the bladder and was oilleting and personal of the resident's care plan 2, revealed "assist with continent episode"		record for Resident #8 per administrative nursing staff indicate any symptoms or or treatment for urinary tract or infection. On 10/30/12, the was placed on alert charting for any signs or symptoms or infection. An education pactincluding the policy for periand infection control/standar precautions, was initiated for nursing staff on 10/30/12. As staff shall receive and review 11/8/12. All new nursing en shall receive packet on hire of the control of t	does not arrent of the rother Resident to observe furinary ket, neal care of a rall ll nursing packet by aployees late. The resident leary tract president learned will one week, then one onal time of the rother of the rother with QA ongoing ograms.	11/16/20

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 and provided are disclosable 14 regram participation.

MOV-08-2012 14:22 LAKESHORE FERNBROOK

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DEPAP	REALTH OF HEALTH	H AND HUMAN SERVICES	NOON				P.003
CENTE	ERS FOR MEDICARE	E & MEDICAID SERVICES				FORM	1 APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mil		E CONSTRUCTION	OMB NO (X3) DATE S COMPLI	
<u>-</u>	,	44A114	B. WIN				
NAME OF !	PROVIDER OR SUPPLIER					10/2	25/2012
	HORE HEARTLAND		.	3025	ET ADDRESS, CITY, STATE, ZIP COD 8 FERNBROOK LANE 8HVILLE, TN 37214	Æ	
(X4) ID PREFIX TAG	I CACH UZFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOUD BE	(X5) COMPLETION DATE
F 315	Continued From pag	ge 1	F 31	15			
t se fin de fin	Technician (CNT) #1 resident. CNT #1 was protective gloves, ap resident and then trained bed, removed the gloves are to the resident's room hands left the resident to the resident's room hands applied protect resumed pericare on cleansing the rectal a changing gloves and labia without separation the gloves and without gait belt to the resident's wheelchair. Review of facility policing from front to backse downward front to backse downward from front t	area of stool and then without I washing hands cleansed the ion. CNT #1 then removed ut washing hands applied a ent to aid with transfer to the order to aid with transfer to the order Cy entitled "Perineal Care",wash perineal area, wiping eparate labia and wash area to back" Cy entitled Hygiene", not dated, as must wash their iter direct resident and gloves hand hygiene is					

disposing of personal protective equipment..."

Interview with CNT #1 on October 24, 2012, at 10:05 a.m., outside the resident's room,

confirmed the resident was cleaned from back to front, the hands were not washed and gloves were not changed after cleaning the rectal area,

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P.004

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPLI	URVEY ETED
	•	44A114	B. WIN	G		5/2012
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 3025 FERNBROOK LANE NASHVILLE, TN 37214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
F 315 F 323 \$\$≂E	and the gait belt was before CNT #1 was 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remains is possible; and	s applied to the resident hed the hands. FACCIDENT	F3	1. On 10/24/12, pull a in both restrooms in 2. On 10/30/12, reside facility were monite Administrator for prisks, with no areas 3. Telephones to enabnursing station will restrooms in question	n question. In the areas of the ored by the otential accident identified. It contact with the be installed in both on.	11/16/2012
	by: Based on interview			4. During the next time meetings, the facility members if there are facility that they are regarding safety or time, the same will annually during Res meetings. Results o will go to the QA Cofurther action.	e areas in the concerned about access. After that be addressed sident Council of this questioning	
	October 23, 2012 for in the Activity Room men's and women's from the Activity Roc Room, on the first fix equipped with emerginterview during the residents were conc to call for help if the heard through the re Observation of the non the first floor of the 2012, at 3:45 p.m., r	eeting with the residents on om 2:30 p.m. until 3:20 p.m., one resident revealed the restrooms located across om, and next to the Dining for of the facility, were not gency pull cords. Continued group meeting, revealed the emed they would be unable residents were not able to be estroom doors. The facility on October 23, evealed neither restroom was shod of alerting staff from the		inchet segon.		

NOV-08-2012 14:22 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P.005 FORM APPROVED

OMB<u>NO. 0938-039</u>1 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATÉ SURVEY IDENTIFICATION NUMBER: COMPLETED A, BUILDING 8. WING 44A114 10/25/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION IŃ PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 Continued From page 3 F 323 inside of the restroom by the residents. Interview with the Director of Nursing (DON) on October 24, 2012, at 8:25 a.m., in the DON's office, confirmed the absence of emergency pull cords in the restrooms located on the first floor of the facility. Interview with the Administrator on October 24, 2012, at 1:20 p.m., in the Administrator's Office. confirmed the absence of emergency pull cords, or other call system, in the restrooms on the first floor of the facility. Continued interview confirmed the residents of the facility also utilized the restrooms during times when staff members were not present on the first floor. Continued interview confirmed the lack of emergency pull cords in the restrooms presented a risk to the resident's safety. 483.25(k) TREATMENT/CARE FOR SPECIAL F 328 F 328 NEEDS S\$=D The facility must ensure that residents receive proper treatment and care for the following special services: Injections: Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care: Tracheal suctioning: Respiratory care; Foot care: and Prostheses. This REQUIREMENT is not met as evidenced bv: Based on medical record review, observation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 44A114 10/25/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (XS) PLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DATE DEFICIENCY) F 328 Continued From page 4 F 328 1. On 10/22/12, Resident #10 was 11/16/2012 and interview, the facility failed to ensure oxygen assessed by LPN and DON. The was administered at two liters per nasal cannula Resident was having an acute change for one resident (#10) of sixteen residents in status and was experiencing reviewed. symptoms of CHF exacerbation. LPN had used nursing judgment and The findings included: increased oxygen flow rate while waiting for response from Resident's Resident #10 was admitted to the facility on physician. LPN obtained order to November 18; 2008, with diagnoses including titrate the oxygen to try to stabilize Dementia, Diabetes, Impaired Renal Function, oxygen saturation. Cerebrovascular Accident, and Anemia. 2. All residents receiving oxygen therapy were audited on 10/22/12 by nursing Medical record review of the Minimum Data Set administration to ensure the correct dated July 16, 2012, revealed the resident was flow rate, per physician order, was in severely cognitive impaired, had short and long place. The following order was added term memory problems, and required total to the physician's routine orders: May assistance with transfers and all activities of daily administer oxygen via nasal cannula or living. facial mask for oxygen saturations less than 91% or shortness of breath. May Medical record review of a Physician Order dated October 22, 2012, revealed, "O2 (Oxygen) at 2L titrate oxygen to maintain oxygen saturations at or above 91%. Oxygen (two liters) PNC (per nasal cannula) PRN (as saturations every shift. Notify MD if needed) (Decrease O2 SATS (oxygen oxygen is administered. saturation), SOB (shortness of breath)" DON, or designee, will review all new oxygen orders to ensure correct flow Observation on October 22, 2012, at 8:00 p.m., in rate is in place, per MD order, for 90 the resident's room, revealed the resident lying in bed with oxygen infusing per nasal cannula at five DON will present for review during liters per minute. quarterly QA meeting. The QA committee will determine if ongoing Interview with the Director of Nursing on October monitoring is needed. 22, 2012, at 8:15 p.m., at the nursing station. confirmed the resident's oxygen was infusing at five liters per minute and the Physician's Orders had not been followed. 483.35(i) FOOD PROCURE, F 371 F 371 STORE/PREPARE/SERVE - SANITARY \$S≃F

P.007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENT	RS FOR MEDICAR	E & MEDICAID SERVICES				FOR	M APPROVE
SIMIFME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI	PLE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY LETED
		44A114	B, W	NG_		1	
NAME OF	PROVIDER OR SUPPLIER			T			<u>/25/2012</u>
LAKESI	HORE HEARTLAND			30	EET ADDRESS, CITY, STATE, ZIP CODE 125 FERNBROOK LANE ASHVILLE, TN 37214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	1111 D RE	(X5) COMPLETION DATE
	The facility must - (1) Procure food from considered satisfact authorities; and (2) Store, prepare, or under sanitary condition of the sanitary condition of the diagonal failed to provide sanitary conditions are unipment. The findings included the findings included to provide sanitary conditions of the diagonal failed in the toaster had continue food coloring, and the conditions of them, and with salad sanitary conditions on them, and with salad sanitary conditions of the co	m sources approved or tory by Federal, State or local distribute and serve food distribute and serve food ditions. This not met as evidenced on and interview, the facility itary storage of food and distribute and compared to or		1 2 3	#1 and #2 1. The food coloring and season were dated on 10/22/12 since had been opened that day. 2. Food will be stored, prepare distributed at all times under sanitary conditions. 3. Dietary staff was in-serviced regarding the need to date all opened items. The cooks wiresponsible to check all item label & date at the end of each opened items. The cooks wiresponsible to check all item label & date at the end of each opened items. The cooks wiresponsible to check all item label & date at the end of each opened items during the monitored by the department CFPP. The RD will check the labeling of opened items during monthly department rounds. The toaster was cleaned by the dietary staff on 10/23/12. The toaster was cleaned by the dietary staff on 10/23/12. Dietary equipment will be maintained in a sanitary mans. A new toaster has been purch replace the toaster in question new toaster will be added to the daily cleaning schedule. This corrective action will be monitored by the department CFPP. The RD will check the toaster during her monthly department rounds. When no are identified for 3 consecutive dientified for 3 consecutive consecutive identified for 3 consecutive dientified for	they d and d d d d d d d d d d d d d d d d d d	11/16/2012

6. Eight drinking glasses were stored wet, and were available for use;

monitoring.

months, the RD will cease this

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DEPAI	TIMENT OF HEALTH	AND HUMAN SERVICES					P.008
CENTI	RS FOR MEDICARE	& MEDICAID SERVICES				FORI	M APPROVED D. 0938-03 91
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		DISTRUCTION	(X3) DATE	
		44A114	B. WING	i		ł	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	<u>.</u>		10/	25/2012
	HORE HEARTLAND		S	3025 FE	DDRESS, CITY, STATE, ZIP CODE PRIBROOK LANE VILLE, TN 37214		
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F 371	The facility must - (1) Procure food from considered satisfact authorities; and	n sources approved or ory by Federal, State or local stribute and serve food	F 37	2. if	The racks in question were and cleaned by dietary staff 10/23/12. Dietary equipment will be naintained in a sanitary marked will be stored, prepare listributed at all times under anitary conditions.	on oner. ed and r	11/16/2012
	by: Based on observation	is not met as evidenced n and interview, the facility ary storage of food and		4. I	The racks were placed on a deaning schedule by dietary his corrective action will be nonitored by the department EPP. The RD will check to turing her monthly department ounds. When no issues are dentified for 3 consecutive the RD will cease this monitors.	y staff. te t CDM, the racks ent months,	
	Observation of the did 22, 2012, from 7:25 prevealed: 1. Open and not dat blue food coloring, an 2. Open and not dat lemon pepper season use; 3. The toaster had distored on a shelf with available for use;	etary department on October		#5 1. T qq 10 2. D m Fo di sa 3. Ti	The container and contents in uestion were discarded on 0/22/12. Interary equipment will be an a sanitary man cod will be stored, prepared istributed at all times under unitary conditions. The containers to be used with eaned by dietary staff on a caning schedule.	n uner. d and	11/16/2012

were available for use:

for use;

debris on them, and were available for use;

5. Salad bar utensils, measuring cups, and

ladies were stored in plastic containers with

debris in the bottom of them, and were available

6: Eight drinking glasses were stored wet, and

monitored by the department CDM,

monthly department rounds. When

CFPP. The RD will check the

plastic containers during her

no issues are identified for 3 consecutive months, the RD will

4. This corrective action will be

P.009

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 44A114 10/25/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) #6 F 371 Continued From page 5 11/16/2012 F 371 The glasses in question were The facility must rewashed on 10/22/12. (1) Procure food from sources approved or Dietary equipment will be considered satisfactory by Federal, State or local maintained in a sanitary manner. authorities: and (2) Store, prepare, distribute and serve food 3. Glass storage trays, which will under sanitary conditions allow for air circulation during drying time, have been purchased and dietary staff is being in-serviced regarding their use. 4. This corrective action will be monitored by the department CDM. This REQUIREMENT is not met as evidenced CFPP. The RD will check the Based on observation and interview, the facility drying process for glasses during failed to provide sanitary storage of food and her monthly department rounds. equipment When no issues are identified for 3 consecutive months, the RD will The findings included cease this monitoring. #7 Observation of the dietary department on October 11/16/2012 1. The steam table pans in question 22, 2012, from 7:25 p.m. until 8:40 p.m., were rewashed on 10/22/12. revealed: Dictary equipment will be Open and not dated 32 ounce container of maintained in a sanitary manner. blue food coloring, and was available for use; Food will be stored, prepared and Open and not dated 28 ounce container of lemon pepper seasoning, and was available for distributed at all times under use; sanitary conditions. The toaster had debris on top of it and was 3. On day shift, all pans will be given stored on a shelf with clean coffee cups; and was at least 5 hours to dry before storing available for use; and overnight for the closing shift Two wire food cooling racks were stored with 4. This corrective action will be debris on them, and were available for use; monitored by the department CDM. Salad bar utensils, measuring cups, and CFPP. The RD will check the steam ladies were stored in plastic containers with debris in the bottom of them, and were available table pans during her monthly for use: department rounds. When no issues 6: Eight drinking glasses were stored wet, and are identified for 3 consecutive were available for use; months, the RD will cease this

monitoring.

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LAKESHORE FERNBROOK

DEPARTMENT OF HEALTH AND HUMAN SERVICES P.010 CENTERS FOR MEDICABLE FORM APPROVED

ATTENDED TO NICE WIELDICARE	<u>: & MEDICAID SERVICES</u>
NIAILUENT AT REPLAISIS S.A.	(X1) PROVIDER/SUPPLIED/CHA

AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

44A114

B. WING_

10/25/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAKE	SHORE HEARTLAND		3025 FERNBROOK LANE
(X4) IC PREFI TAG		ID PREFII TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION
F 37	7. Five steam table pans were stored wet, and were available for use; 8. Serving trays and baking pans were stored with debris and dust on them on a shelf with clean coffee cups, and were available for use. Interview with the head cook and the dietary department manager on October 22, 2012, at 8:40 p.m., in the dietary department, confirmed the food coloring and the lemon pepper seasoning were to have been dated when opened. Continued interview, at that time, confirmed the toaster, wire cooling racks, and serving trays and pans were to be cleaned before being stored in a clean area and all utensils, measuring cups, and ladles were to be properly stored in clean containers; drinking glasses, and steam table pans were to be dried prior to being stored for use.	F3	#8 1. The serving trays from outside functions were discarded on 10/22/12. 2. Dietary equipment will be maintained in a sanitary manner. 3. Serving trays from outside functions will not be stored in the kitchen area in the future. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the presence of trays from outside functions during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #9
\$5≖E	Continued observation on October 24, 2012, at 8:05 a.m., in the dietary department, revealed a circulating fan on a pedestal in the on position and blowing over a food prep area. Interview with the dietary manager on October 24, 2012, at 8:08 a.m., in the dietary department, confirmed "you can't have a fan blowing over food." 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	1. The ran was removed from the kitchen area on 10/24/12. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. Use of pedestal fans will not be allowed in the kitchen area.
RM CMS-250	17(02-99) Previous Versions Obsolete Event ID:138011	<u> </u>	Sellity (D) Talened

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NOV-08-2012 14:23 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		rple construction ng	(X3) DATE S COMPLI	
		44A114	B. WI	NG_		10/2	5/2012
	PROVIDER OR SUPPLIER IORE HEARTLAND SUMMARY STA	TEMENT OF DEFICIENCIES	מו	3	REET ADDRESS, CITY, STATE, ZIP CODE 5025 FERNBROOK LANE NASHVILLE, TN 37214 PROVIDER'S PLAN OF CORRE		~~~~
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	(X6) COMPLETION DATE
	(a) Infection Control The facility must est Program under whice (1) Investigates, cort in the facility; (2) Decides what proshould be applied to (3) Maintains a record actions related to interest to interest the interest that a represent the spread of isolate the resident. (2) The facility must communicable disect from direct contact will train the interest to interest contact will train the interest that it is indicated in the interest contact will train the interest conta	Program tablish an Infection Control th it - introls, and prevents infections occdures, such as isolation, an individual resident; and rd of incidents and corrective fections. ad of Infection on Control Program sident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if unsmit the disease. require staff to wash their ect resident contact for which cated by accepted		141	 On 10/29/12, medical record Residents #8 and #2 were readministrative nursing stafficurrent treatments for infect place or signs/symptoms of tract or other infections are above stated residents. On hand washing check-off she initiated with nursing staff. Observations are to be conditionally nursing administrative staff. 10/29/12, nursing administrative staff. 10/29/12, nursing administrative began observations for hand during medication pass or to On 10/30/12, observations for care were initiated by licens staff. On 10/29/12, education was for nursing staff including in control and hand washing, staff will have received and education packets by 11/8/1 nursing employees will receive we education packet on Nursing administrative staff observe 4 times a week for a wonce a week for 4 weeks, whadditional training provided at the time of observation. The DON, or designee, will results each week. The QA will review on next quarterly to determine if continued perimprovement programs are improvement programs are improvement programs are in the plant of the programs are improvement programs are improvement programs are in the plant of the programs are improvement programs are in the plant of the programs are in the plant of the programs are in the plant of the plant of	wiewed by No ions are in urinary noted for 10/24/12, ets were ucted by On ative staff washing eatments. or perineal ed nursing initiated affection All nursing reviewed 2. All new ive and hire date. will one week, eeks, then ith as needed monitor Committee y meeting afformance	11/16/2012

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CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 44A114 10/25/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION PŘĚFIX (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 441 Continued From page 8 F 441 change for one resident (# 2), failed to ensure staff washed hands and changed gloves during incontinence care for one resident (#8), and failed to ensure staff maintained infection control practices during a medication administration for sixteen residents reviewed. The findings included: Observation on October 23, 2012, at 1:30 p.m., revealed the facility's treatment nurse performing a dressing change on resident's (#2) right heel. Observation revealed the treatment nurse placed a clean barrier on the over bed table and placed the clean supplies on the barrier without cleansing the table. Observation revealed the treatment nurse washed the hands, applied gloves, removed the old dressing from the right heel, and discarded the dressings in a plastic bag. Continued observation revealed the treatment nurse cleansed the wound, measured the wound, and applied a clean dressing to the right heel without removing gloves or washing the hands. Continued observation of the treatment nurse performing the dressing change on the resident's left heel revealed the treatment nurse washed the hands, applied gloves, removed the old dressing from the left heel, and discarded the dressings in a plastic bag. Continued observation revealed the treatment nurse cleansed the wound, measured the wound, and applied a clean dressing to the left heel without removing gloves or washing the hands. Review of the facility's Wound Care Policy revealed, "...Put exam glove. Loosen tape and

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		44A114	B. WING_		10/2	5/2012
	PROVIDER OR SUPPLIER		34	EET ADDRESS, CITY, STATE, ZIP CODE 025 FERNBROOK LANE ASHVILLE, TN 37214		
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 441	remove dressing. P discard into approp dry your hands thor Interview with the tr 2012, at 2:00 p.m., confirmed the over prior to applying a c were not washed be and applying a clea Resident #8 was ac 11, 2010, with diagr with Behaviors, Der Hypothyroidism. Medical record revid dated October 9, 20 frequently incontine totally dependent for hygiene care. Medical record revid dated October 17, 2 peri care after each Observation on Oct the resident's room Technician (CNT) # resident. CNT #1 w protective gloves, a resident and then tr bed, removed the g supplies to perform hands left the resid to the resident's roo hands applied prote	ge 9 uli glove over dressing and riate receptacle. Wash and oughly. Put on gloves" eatment nurse on October 23, at the nursing station, bed table was not cleansed dean barrier and the hands etween cleansing the wound in dressing for both heels. Imitted to the facility on June roses including Alzheimer's pression, Osteoarthritis, and ew of the Minimum Data Set 112, revealed the resident was int of the bladder and was int of the bladder and was into the bladder and applied performing pericare on the vashed the hands and applied pplied a gait belt to the ansferred the resident to the loves to retrieve additional pericare, and without washing the into the gloves. CNT #1 returned in and without washing the octive gloves. CNT #1 then in Resident #8 by first	F 441			

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Statemen And Plan	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLE	URVEY ETED
_		44A114	B. WING		10/2	5/2012
	ROVIDER OR SUPPLIER	•	30	EET ADDRESS, CITY, STATE, ZIP CO 225 FERNBROOK LANE ASHVILLE, TN 37214	ODE	<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
	changing gloves an labia. CNT #1 then without washing hal resident to aid with wheelchair. Review of facility po "Handwashing/Handrevealed "employs handsbefore and contactafter remo always the final step disposing of person Interview with CNT: 10:05 a.m., outside confirmed the hands were not changed a and the gait belt was before CNT #1 wash before CNT #1 wash Changed RN #1 drop packaging onto the for Med Pass Residerevealed RN #1 drop packaging onto the formedication cup, carrinto the resident's roreturned to the medication with glove medication cup for a series of the series of the medication cup for a series of the medication	area of stool and then without d washing hands cleansed the removed the gloves and had applied a gait belt to the transfer to the resident's dicy entitled d Hygiene", not dated, ses must wash their after direct resident wing gloveshand hygiene is after removing and all protective equipment" #1 on October 24, 2012, at the resident's room, swere not washed and gloves fter cleaning the rectal area, is applied to the resident need the hands. Medication Administration on the 8:55 a.m., revealed RN) #1 preparing medications ent A. Continued observation, oped a pill from the original top surface of the medication ration revealed RN #1 picked from the cart using a paper fied the medication in the cup om, donned a pair of gloves, cation cart and placed the fied hand into the resident's	F 441			
		e resident's room, confirmed	1			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	lultipu Ilding	E CONSTRUCTION	(X3) DATE S COMPL	
		44A114	B. WI	4G		10/2	25/2012
	PROVIDER OR SUPPLIER			302	ET ADDRESS, CITY, STATE, ZIP COI 5 FERNBROOK LANE SHVILLE, TN 37214	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
F 441	RN #1 was going to after the medication surface of the medi interview confirmed medication because Further interview wisurface of the medi Continued observat Administration with at 9:05 a.m., outside RN #1 placed Resid locked drawer, enterwash her hands and cart. Continued obsunlocked the drawer removed the reside drawer, picked up the into a seperate cup, knocked on the reside drawer without rewashing her medications on the without rewashing her medications to the revealed RN #1 the located in the reside container of eye drops in the reside eye drops in the residence.	administer the medication in had been dropped on the cation cart. Continued I RN #1 would administer the efficient of the touch the floor. It is RN #1 confirmed the top cation cart was not clean. It is rection to the floor of the top cation cart was not clean. It is rection to the floor of the resident A's room, revealed the resident A's room, revealed the resident are red to the medication of the medication cart, in the medications, closed the resident's bedside table, and her hands, administered PO resident. Further observation in donned a pair of gloves ent's room, picked up a pps, and then administered sident's eyes without washing or the administration of the	F	441			
	revealed handwash and after direct residual hygiene is indicated practice)", and " replace handwashir	olicy, entitled d Hygiene", not dated, ing is required "5c. Before dent contact (for which hand by acceptable professional 8. The use of gloves does not ng/hand hygiene" Continued icy revealed, "7. Hand					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		44A114	B. WING		10/2	5/2012
	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, YN 37214		
(X4) IID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DAYE
F 441	hygiene is always to and disposing of per equipment" Interview with RN # 9:10 a.m., outside to RN #1 did not follow practices during mare resident.	ne final step after removing ersonal protective of on October 23, 2012, at the resident's room, confirmed by proper infection control edication administration to the	F 441	1 On 10/24/12 will alarms w	ere placed	11/16/2012
F 463 \$\$=E	ROOMS/TOILET/B The nurses' station resident calls through		F 463	in both restrooms in que 2. On 10/29/12, resident ar facility were monitored Administrator for potent risks, with no areas iden 3. Telephones to enable co nursing station will be in restrooms in question.	tion. as of the yethe as of the yethe al accident fied. tact with the talled in both	
	by: Based on interview failed to maintain a men's and women's residents on the first. The findings include During the group moctober 23, 2012 from the Activity Room, men's and women's from the Activity Room, on the first frequipped with emerinterview during the residents were considered.	eeting with the residents on rom 2:30 p.m. until 3:20 p.m., n, one resident revealed the restrooms located across rom and next to the Dining loor of the facility, were not regency pull cords. Continued group meeting revealed the cerned they would be unable residents were not able to be		4. During the next three Residence meetings, the facilitator will members if there are areas facility that they are concernegarding safety or access. time, the same will be addranged annually during Resident Connectings. Results of this quill go to the QA Committee further action.	il ask the in the med about After that essed council uestioning	

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		(X1) PROVIDER/SUPPLIER/CLIA .(DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		44A114	B. WIN	IG		10/2	25/2012
	PROVIDER OR SUPPLIER		-	3028	ST ADDRESS, CITY, STATE, ZIP CODE S FERNBROOK LANE SHVILLE, TN 37214		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 463	Observation of the ron the first floor of the 2012, at 3:45 p.m., equipped with a me inside of the restrood Interview with the D October 24, 2012, a office, confirmed the cords in the restroof the facility. Interview with the Ac 2012, at 1:20 p.m., i confirmed the abservation of the facility. It is residents of the restrooms during time to present on the facility of the restrooms during time to present on the facility.	men's and women's restrooms he facility on October 23, revealed neither restroom was thod of alerting staff from the	F4	63			